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Excellence In Health Care

Karyotyping (Chromosome Analysis) Clinical History Form

CLIENT CODE & CLIENT NAME: SPL-SO-039 Lab Reference No.: _____

Accession No. (For Lab use only): _____

Patient's Name: Mrs. Sneha Vishal Hawale

Date of Birth: 17/10/2002 Age: 23 years Gender: M/ F/ TG

Date & Time of Sample Collection: 22/06/2025

Clinician's Details

Name: _____ **Contact Number:** _____

Specimen Submitted

[✓] Whole Blood [] Tissue [] Any Other _____

Indication of Test: karyotyping

Relevant Clinical History of Patient: Pt H/O ? Mongol . ? Trisomy 21 aborted at 20wks

Consanguineous Marriage (Married to close relatives) [✓] Yes [] No

Number of Conceptions

No. of Births: 0 No. of Abortions: 1 Delivery: Children: Surviving 0 Expired 0

Mother's Age at the time of Patient's Birth (Applicable for children): _____

- Congenital Deformity in Mother: [] Yes [] No
- If Yes, Please specify physical or mental

Father's Age at the time of Patient's Birth (Applicable for children): _____

- Congenital Deformity in Mother: [] Yes [] No
- If Yes, Please specify physical or mental

Family History of Congenital Defect (if applicable)

- Maternal Relatives [] Yes [✓] No if Yes Please Specify Physical or Material
- Paternal Relatives [] Yes [✓] No if Yes Please Specify Physical or Material

Any Congenital Deformity in Grandparents

- Maternal Relatives [] Yes [✓] No if Yes Please Specify Physical or Material
- Paternal Relatives [] Yes [✓] No if Yes Please Specify Physical or Material

No. of Siblings: Male: 00 Female: 00

Any Congenital deformity in Siblings: [] Yes [✓] No If Yes, Please Specify Physical or Material

_____

_____

Name & Signature of Patients / Guardian

Name & Signature of Requisitioner